STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

May 4, 1989

TO: All County Welfare Directors
All County Administrative Officers

Letter No.: 89-32

SUBJECT: REVISED IRCA/OBRA NOTICES OF ACTION

Reference: All County Welfare Directors Letter 88-66

Enclosed with this letter are corrected versions of three of the five notices of action sent to you previously as Attachment 3 to ACWDL 88-66 (IRCA/OBRA PROCEDURES SB175):

- MC239P (4/89): BENEFITS RESTRICTED TO EMERGENCY MEDICAL AND PREGNANCY-RELATED SERVICES
- MC239Q (4/89): CHANGE FROM RESTRICTED SERVICES TO FULL BENEFITS
- MC239S (4/89): APPLICATION FOR RETROACTIVE EMERGENCY MEDICAL AND PREGNANCY-RELATED SERVICES

Two of the notices you have been using have now been eliminated: MC239-0 (9-88) and MC239T (9-88). Instead of the MC239-0 (9/88): DENIAL/DISCONTINUANCE OF RESTRICTED BENEFITS, we ask you to use existing form MC239A: DENIAL/DISCONTINUANCE OF BENEFITS. Questions formerly asked on the MC239T (9/88): APPROVAL FOR EMERGENCY MEDICAL AND PREGNANCY-RELATED SERVICES have been incorporated into the revised MC239P.

Please reproduce your own supply of the enclosed corrected versions and start to use them as soon as possible. We expect to have the English notices in the Forms Warehouse by the end of May. The Spanish notices should be available soon thereafter.

Eligibility Branch wishes to thank all the county welfare staff who assisted us with this project. If you have questions about the notices, please call Tom Dickson at (916) 324-4961.

Sincerely,

Original signed by

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: May 4, 1990

COUNTY STAMP

MEDI-CAL NOTICE OF ACTION
BENEFITS RESTRICTED TO EMERGENCY MEDICAL AND PREGNANCY-RELATED SERVICES

Case Name: _____

Case Number: _____

District: _____

Restriction of Benefits For: _____

_____

_____ (names)

Effective _____ (month), you will begin receiving a Medi-Cal card which will allow you to receive emergency medical and pregnancy-related services. Always present this card to your doctor or other Medi-Cal provider when you request such services.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in any of the following: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction to any bodily organ or part. The emergency must be certified by a physician or other appropriate medical provider (in accordance with Section 51056 of Title 22 of the California Code of Regulations). The Department of Health Services may review the provider's decision that an emergency existed and that certain follow-up treatment services were medically justified.

Pregnancy-related care means services required to assure the health of the pregnant woman or the unborn child. Pregnancy care may be provided prenatally and up to 60 days postpartum.

☐ Your application for restricted benefits has been approved.

☐ Your application for full benefits is denied. You are granted, instead, eligibility for emergency medical treatment and pregnancy-related services.

We are taking this action because you are an alien who:

- ☐ Is not legally present in the United States according to information received from the Immigration and Naturalization Service.
- ☐ Lacks documentary proof from the Immigration and Naturalization Service of a satisfactory immigration status for Medi-Cal purposes.
- ☐ Has been admitted to the United States as a nonimmigrant for a limited period of time.
- ☐ Has been legalized in accordance with Section 210, 210A, or 245A of the Immigration and Nationality Act and you are not blind or disabled, not aged (65 or over), not under 18 years of age, or not a Cuban/Haitian Entrant.

☐ Since your income was more than the amount allowed for living expenses, you must pay or obligate a share of the cost of your medical care. Your share of cost is $_____ beginning _____ (month). Your share of cost was computed as follows:

	MONTH 1	MONTH 2	MONTH 3
Gross Income	$_____	$_____	$_____
Net Nonexempt Income	$_____	$_____	$_____
Maintenance Need	$_____	$_____	$_____
Excess Income	$_____	$_____	$_____
Share of Cost	$_____	$_____	$_____

Please follow the instructions on the reverse side of the RECORD OF HEALTH CARE COSTS. After that form has been completed and approved, you will receive your restricted services Medi-Cal Card.

This action is required by Section 14007.5 of the Welfare and Institutions Code and California Code of Regulations, Title 22, Section(s) _____.

If you have questions about this action, please write or telephone. We will answer you over the telephone, in writing, or we will make an appointment to see you in person.

You must report all changes in your immigration status to us. A change in status may qualify you to receive full Medi-Cal benefits rather than just restricted services.

_____ (Eligibility Worker) _____ (Phone) _____ (Date)

PLEASE READ THE REVERSE SIDE OF THIS NOTICE

YOUR HEARING RIGHTS

To Ask For a State Hearing

The right side of this sheet tells how.

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we mailed this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

To Keep Your Same Benefits While You Wait For a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

To Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid ☐ Food Stamps

To Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free:	1-800-952-5253
If you are deaf and use TDD call:	1-800-952-8349

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

You may get free legal help at your local legal aid office or welfare rights group.

Other Information

Child Support: The District Attorney's office will help you collect child support even if you are not on cash aid. There is no cost for this help. If they now collect child support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask.

saring File: If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W. & I. Code Section 10950)

NA BACK 6

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and send or take it to:

You may also call 1-800-952-5253.

HEARING REQUEST

I want a hearing because of an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) _____

Here's why: _____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

I will bring this person to the hearing to help me (name and address, if known):

_____

_____

_____

I need an interpreter at no cost to me. My language or dialect is: _____

My name: _____

Address: _____

_____

Phone: _____

My signature _____

Date: _____

State of California—Health and Welfare Agency

Department of Health Services

MEDI-CAL NOTICE OF ACTION
CHANGE FROM RESTRICTED SERVICES TO FULL BENEFITS

COUNTY STAMP

Case Name: _____

Case Number: _____

District: _____

Approval For: _____

_____

_____

_____
(names)

You are eligible effective _____ to receive all the services covered by the Medi-Cal
(month)
Program rather than just services restricted to treatment of an emergency medical condition or pregnancy-related care. This change in scope of benefits results from the fact that:

☐ Proof has been received from the Immigration and Naturalization Service that you are an alien who has a satisfactory immigration status for Medi-Cal purposes.

☐ You are an alien legalized in accordance with Section 210, 210A, or 245A of the Immigration and Nationality Act and you are aged (65 or over), blind, disabled, under age 18, or a Cuban/Haitian Entrant.

You will receive a full coverage Medi-Cal card soon. Always present this card to the doctor or any other Medi-Cal provider when requesting medical services.

☐ Since your income exceeds the amount allowed for living expenses, you have a share of cost to pay or obligate toward your medical care. Your share of cost is $_____ beginning _____ (date). Your share of cost was computed as follows:

	Month 1	Month 2	Month 3
Gross Income	$_____	$_____	$_____
Net nonexempt income	$_____	$_____	$_____
Maintenance need	$_____	$_____	$_____
Excess income	$_____	$_____	$_____
Share of cost	$_____	$_____	$_____

Enclosed is a RECORD OF HEALTH CARE COSTS. Please follow the instructions on the reverse side of that form. A full coverage Medi-Cal card will be issued to you after the form has been completed and approved.

☐ A full coverage Medi-Cal card showing the share of cost will be mailed to you at your long-term care facility each month.

This action is required by California Welfare and Institutions Code, Section 14007.5 and by the California Code of Regulations, Title 22, Section(s) _____

_____

_____ _____ _____
(Eligibility Worker) (Phone) (Date)

PLEASE READ THE REVERSE SIDE OF THIS NOTICE.

MC 239Q (4/89)

YOUR HEARING RIGHTS

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To Keep Your Same Benefits While You Wait For a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

To Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid ☐ Food Stamps

To Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free:	1-800-952-5253
If you are deaf and use TDD call:	1-800-952-8349

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

You may get free legal help at your local legal aid office or welfare rights group.

Other Information

Child Support: The District Attorney's office will help you collect child support even if you are not on cash aid. There is no cost for this help. If they now collect child support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask.

Hearing File: If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W. & I. Code Section 10950)

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☐ Other (list) _____

Here's why: _____

_____

_____

_____

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I will bring this person to the hearing to help me (name and address, if known):

_____

_____

_____

I need an interpreter at no cost to me. My language or dialect is: _____

My name: _____

Address: _____

_____

Phone: _____

My signature _____

Date: _____

(County Stamp)

MEDI-CAL NOTICE OF ACTION APPLICATION FOR RETROACTIVE EMERGENCY MEDICAL AND PREGNANCY-RELATED SERVICES

Case Name: _____

Case Number: _____

District: _____

Approval/Denial For:

_____

_____
(Names)

We have reviewed all the information in your case file which relates to your application for retroactive emergency medical and pregnancy-related services. Our findings are indicated below.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in any of the following: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction to any bodily organ or part. The emergency must be certified by a physician or other appropriate medical provider (in accordance with Section 51056 of Title 22 of the California Code of Regulations). The Department of Health Services may review the provider's decision that an emergency existed and that certain follow-up treatment services were medically justified.

Pregnancy-related care means services required to assure the health of the pregnant woman or the unborn child. Pregnancy care may be provided prenatally and up to 60 days postpartum.

☐ You are entitled to receive Medi-Cal benefits restricted to emergency and pregnancy-related services for _____

Since your income was more than the amount allowed for living expenses, you must pay or obligate a share of the cost of your medical care.

	MONTH 1	MONTH 2	MONTH 3
Gross Income	$_____	$_____	$_____
Net Nonexempt Income	$_____	$_____	$_____
Maintenance Need	$_____	$_____	$_____
Excess Income	$_____	$_____	$_____
Share of Cost	$_____	$_____	$_____

Enclosed is a RECORD OF HEALTH CARE COSTS for each of the months listed. Please follow the instructions on the reverse side of that form. When each form has been completed and approved, a restricted-services Medi-Cal card will be issued to you for that particular month.

☐ You are not entitled to receive Medi-Cal benefits restricted to emergency and pregnancy-related services for _____ (Months) for the following reason(s):

This action is required by Section 14007.5 of the Welfare and Institutions Code and California Code of Regulations, Title 22, Section(s)

_____

This action does not affect your application for current and continuing Medi-Cal. If you have any questions or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions over the telephone, in writing, or will make an appointment to see you in person.

_____ (Eligibility Worker) _____ (Telephone Number) _____ (Date)

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☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) _____

Here's why: _____

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I will bring this person to the hearing to help me (name and address, if known):

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My name: _____

Address: _____

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My signature _____

Date: _____